MOTION FOR SUMMARY JUDGMENT ON BEHALF OF WE ARE SHARING HOPE SC, AND DARLA WELKER

EXHIBIT E

Welker Dep, Dec. 14, 2020

Deposition of:

Darla A. Welker

December 14, 2020

In the Matter of:

Holliman, Michelle v. We Are Sharing Hope SC, et al

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STATE OF SOUTH CAROLINA COURT OF COMMON PLEAS
COUNTY OF CHARLESTON 9TH JUDICIAL CIRCUIT
MICHELLE CHA HOLLIMAN, individually and as personal representative of the Estate of Allen B. Holliman,

Plaintiff,

vs. CASE NO. 2020-CP-10-2902

WE ARE SHARING HOPE SC, MEDICAL UNIVERSITY OF SOUTH CAROLINA, and UNITED NETWORK FOR ORGAN SHARING,
Defendants.

VIDEOCONFERENCE
DEPOSITION OF: DARLA A. WELKER

DATE: December 14, 2020

TIME: 10:04 a.m.

LOCATION: Mount Pleasant, South Carolina

TAKEN BY: Counsel for the Plaintiff

REPORTED BY: MARIE H. BRUEGGER, RPR, CRR
(Appearing Via VTC)

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I N D E X

REQUESTED INFORMATION INDEX

(No Information Requested)

E X H I B I T S

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Q Would you say that you supervise the process?
A In somewhat of a manner, yes, yes.
Q So can you just go into a little bit more detail, please, about what it is on a particular donor's case that you would be doing as the AOC?
A From when the donor starts, we ensure that the appropriate person is on site to begin the donor, that we are sending out specimens, that we are -- as the case goes along, that we're -- it's kind of hard to put this into context that you could understand, but we basically make sure that the blood gets drawn, that it gets sent, that when we start allocating, that the organs are allocated in an appropriate manner. When an OR -- when an organ can't be used for transplant and exhausted all opportunities, we guide them to set the OR. We communicate with other staff that's going to be involved in the OR and making sure that they bring in the appropriate equipment to the OR. We just kind of make sure that everybody is in the place that they're supposed to be at the time.
Q You mentioned about sending out

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specimens and making sure blood gets drawn and gets sent. Can you tell me where does -- where all does blood get sent?
A So we send serologies and NATs to VRL in Norcross, Georgia. We send HLA blood to MUSC.
Q Is there anything else?
A Huh-uh.
Q What is the difference between those types of specimens?
A The serologies and NATs that are sent to Atlanta, to Norcross, those reveal infectious diseases as well as NATs, which is a higher level of testing, and the blood type, all sent on the same specimens. The HLA is more of a genetic determinant of if a particular organ from a genetic component would match a recipient based on their HLA typing, which is somewhat of a -- like if you were to do a parental test, it's somewhat on that level of a test.
Q And MUSC does all of the HLA typing for donors. Is that right?
A Yes.
Q And do all donors get NATs testing?
A Yes.
Q And is that done by VRL?

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A Yes.
Q What percentage of your time is spent in your role as manager of research versus administrator on call?
A I am typically on call one to two days a week. The rest of my time is spent in the office as manager of research. It's hard to say week to week based on the schedule.
Q Has that approximate division changed over the last five years?
A Yes. We've -- yes, it has.
Q Can you explain that change to me?
A We just have more administrators on call currently.
Q So your time as administrator on call has diminished in the past five years?
A Yes.
Q So five years ago, how much time, approximately, were you spending as an AOC?
A It was probably about the same, one to two days a week. That's -- the schedule varies. It's never the same month to month.
Q But then you said there are just more people in that position now than there used to be?
A Yes.

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Q As an AOC, are you involved with determining and reporting the blood type of organ donors?
A Yes.
Q And can you describe your involvement with that, please?
A The blood type is, again, sent with VRL -- to VRL for two samples that are drawn at two different times, and we also run a hospital ABO in the beginning.
So when we receive the two VRL specimens, those are received by the clinical allocation technician. When those are received, they would then report them to the on-site clinician, and then they notify me as to the results of those two samples that were drawn. And then I verify that it's the correct donor with the correct UNOS ID, the correct birthdate, the correct collection time for both of those, and verify that those two ABOs match.
Q And you also mentioned running a hospital ABO?
A Correct.
Q Can you tell me a little bit about that, please?

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A Again, it's the same verification process for the donor blood type. We verify that it's the correct patient, correct date of birth, and the date and time collected and what the -- what the blood result was, the ABO result was.
Q Why do you run a hospital ABO in addition to the test done by VRL?
A Because in the beginning, if we have a donor that has blood type A or AB, we can subtype off of that sample, and it's used for subtyping.
Q You're saying the hospital ABO is used for subtyping?
A It's not in of itself used as subtyping. It's a guide to whether we can subtype or use the subtype that VRL uses -- sends -- reports I guess is a better word.
Q So is it used to verify the VRL results? Is that what you're saying?
A It's an indication, if we have an A or an AB, that the two samples that we get that we run at VRL can be subtyped as an A1 and A2 or an A12 or an A1 or A2B.
Q So the -- and I'm sorry if -- I'm not nearly as familiar with all this as you are, so I'm sorry if it seems like I'm asking silly

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questions.
So you're saying the hospital ABO is used for subtyping blood types A and B. Is that correct?
A Can be, but not only for subtyping. It can be used as a blood type, a reported blood type, as well.
Q So why do you get the hospital ABO in addition to the VRL results?
A Because, again, it just gives us an indication if the patient is an A or an AB. And it's always been a set of our standard orders to obtain a hospital ABO.
Q So you do that for every donor?
A Yes, we do that for every donor.
Q And is that one that WASH asks for the hospital to perform?
A Correct.
Q Do you review medical records of potential organ donors as part of your job?
A Not routinely. That is the responsibility of the on-site clinician.
Q And who is the on-site clinician?
A That would be Michael Lotts.
Q Is he it for all donors?

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A No. And there would have been -- at different times when the case starts, there are other clinicians on. Michael was on that particular day.
Q For the donor at issue in this case?
A Yes, for the donor the day that the blood type was typed as well as for the OR and the recovery in the OR.
Q So would it have been his role to review the medical records of the donor at issue in this case?
A Yes.
Q Are you responsible for approving the blood type reported for donors that you're working on?
A Yes.
Q And what do you do in order to approve a blood type reported for a donor?
A Again, I look at the two samples that are drawn at VRL to compare those two, and if they're the same blood type, then we would report those and verify those two ABOs as the reported case of what the -- that's the normal practice. So those two blood types match, they have the -- it's the right donor, the right -- the right VRL

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form, requisition form drawn at two separate times, both the same result. Those are reported as the ABO.
Q And so what happens if those VRL results don't match?
A We utilize the hospital ABO. So our policy and practice is if we have an indeterminate ABO from VRL, our policy states or allows for us to use two different samples drawn at two different times.
And we had the initial ABO, and I don't remember the date and time, but I do recall that it was -- and then Michael and I spoke about ordering a second ABO when we got the indeterminate results on this particular case, and Michael -- while we were on the phone, Michael reported that he'd found another blood type that was drawn approximately 23 hours later, on a different date, and the result was the same, so we had two ABOs that were reported by the hospital as being O. And if we had two samples that reported at two different times, per UNOS policy and WASH policy, we were allowed to use those two samples.
Q And so you just were describing the blood typing results for the donor at issue in

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massively transfused, we put in place a hard stop on the case, and that cannot be released until the medical director has reviewed all of the blood types and releases that blood type as being resulted as what they determine it to be with their investigation.

Q And when was that procedure put in place?

A Shortly after this event.

Q And it was put in place because of this event?

A Yes.

Q In November 2018, did the medical directors get involved in a donor who had had massive blood transfusions?

A I don't recall the extent, but again, that sample -- we had two samples drawn at two different times that were -- resulted the same by the hospital, and that was within WASH's policy as well as UNOS's policy, so we -- no, I don't recall that we did at that point just because we had two resulted samples that were the same.

Q So you're saying you don't recall that the medical directors became involved in this donor's case?

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A Correct.

MS. CRAIG: Object to the form of the question.

BY MS. DINKINS:

Q As a general matter, though, would the medical directors in 2018 become involved in a donor who had had massive blood transfusions?

A I can't recall 100 percent. I can't recall. That would be speculation. I don't recall.

Q Who is your supervisor at WASH?

A That is Dave DeStefano.

Q Who was it in November 2018?

A That was Jeff Thomas.

Q What was Jeff Thomas's role?

A He was the chief clinical officer.

Q What is that?

A He was over both tissue and organ departments and --

Q So what did he do?

A Oversaw daily operations of both departments.

Q Is he still at WASH?

A He is not.

Q When did he leave?

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A I believe it was the beginning of -- end of 2019/early 2020.

Q Do you know why he left?

A I do not.

Q Does anyone at WASH report to you?

A No.

Q Did anyone at WASH report to you in November 2018?

A No.

Q So did Janine Bumgarner report to you for this donor's case?

A Yes, in the capacity of an AOC, but not as my direct employee.

Q I understand. Can you please describe who reports to you in your capacity as an AOC?

A So that is the clinical donation coordinator, the clinical allocation technician, and the CDS, which is the clinical donation specialist.

Q And can you describe how those people report to you?

A Again, the clinical person that's on site just reviews the case with me in regards to where they are in terms of like procedures that they're doing, when we're allocating organs, where

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we are on a list. We keep in contact with that to ensure that we're following the list and that we're placing organs in an appropriate time.

Once we have everything coordinated, they report to me as to when we're going to establish an OR, because -- mainly those types of oversight processes. The clinical allocation technician, again, is the person who is allocating the organs at home, the ABO, obviously, also again when -- they're coordinating with the on-site clinician as well, but I sort of oversee their processes where they overlap in terms of allocating the organs off the list and setting an OR.

And then the clinical donation specialist is the -- our folks who come in in the OR and assist with the recovery and final placement of the organs and are helping to arrange transportation for the organ to reach its destination.

Q Has your interaction with the CDCs, CATs, and CDSs changed since 2018?

A My interaction, no, as far as what I'm responsible for with my role, no.

Q Did you undergo any type of training

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Text message?
A We do it -- there's a two-step verification. The first verification is in our medical record, and then the second verification is in -- so that's done with the CAT and myself. And then the second verification is done in DonorNet. Again, that's with the CATs. The CAT will go in and add the first ABO into DonorNet, and then I would go behind them in DonorNet and verify the ABO as well, and they have to be the same ABO.
Q For the first step between the CAT and you, do you give that approval to the CAT in writing?
A It's documented in our electronic medical record.
Q What is that? What does that documentation look like?
A It's a field in our electronic medical record that verifies where the specimens were drawn, if it was a hospital ABO, if it was a VRL ABO, where it was drawn, and then we just are verifying that we have two different samples drawn at two different times that are the same result, and we verify it as our name and our user log-in.

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Q Is that a particular form?
A It's electronic.
Q I guess I'm not quite following. What do you mean by it's electronic?
A It's part of a page in our electronic medical record system that we -- that the CAT would go in and put in the blood type and then verify where the samples were drawn and then put in her user name and her password to verify that particular ABO.
Q Is that called the CAT ABO verification?
A I was getting a call. Let me turn my phone off. Can you still hear me?
Q I can.
A So that was the first -- that's the first step in the verification process. Second step is to go into DonorNet and to go into the ABO pending page and verify the ABO that the CAT initially put in. And those two have to match.
Q And when you -- is there an electronic record of that verification?
A That would be in the DonorNet record.
Q And is your name by the verification?
A I can't see it once it's verified, but

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I'm assuming that it's kept in DonorNet somewhere who did the verifications.
Q Can you please describe what you do in general to approve a donor's blood type?
MS. CRAIG: Object to form, "approved."
THE WITNESS: So I'm supposed to answer that one, correct?
MS. CRAIG: Yes. And, Darla, you're supposed to answer all questions unless I specifically instruct you not to answer it.
THE WITNESS: Okay.
MS. CRAIG: Thank you.
THE WITNESS: In general practice, again, we receive serologies which contain -- and NATs which contain two different samples drawn for blood typing. They're drawn at two different times. So we verify that it's the same UNOS ID on both of those samples, that they're drawn at two different times, or collected at two different times is actually how it's stated on the form, and that it's the same requisition form, and that those two ABOs match.
BY MS. DINKINS:
Q And what did you do to approve this

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donor's blood type?
MS. CRAIG: Object to form.
THE WITNESS: Those two results came back indeterminate. And when those two came back indeterminate, I first spoke with Janine, and then I called Michael or Michael called me, I'm not 100 percent certain, and we discussed drawing another blood type. And Michael informed me that he had a second ABO at the hospital that was drawn approximately 24 hours out from the first ABO that was drawn, and that they both resulted in an O. So we had two samples that were drawn at two different times that both resulted in an O, and so we followed our Sharing Hope policy as well as UNOS guidelines.
BY MS. DINKINS:
Q Did Michael tell you that the donor had received blood transfusions?
A I don't recall.
Q Did you ask him whether the donor had received any transfusions?
A I don't recall.
Q Why did you think that the VRL results came back indeterminate?
A Sometimes samples are hemodiluted

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THE WITNESS: That's not my job to be --
MS. CRAIG: Darla, just one minute. Lucy, are you talking about a particular policy? And if so, could you show her the policy that you're talking about?
MS. DINKINS: I'm talking about the OPTN policies as a whole.
MS. CRAIG: So could you show her the actual policy that you're referring to?
MS. DINKINS: I'm just asking whether she was familiar with them in 2018.
THE WITNESS: It is not my role to be completely familiar with all the policies; that's quality's role. Our role is to have a general overview of these specific policies that play into our process as AOCs.
So at the time, I do know 100 percent certain that two ABOs drawn at two different draw times were -- was sufficient for OPTN policy as well as We Are Sharing Hope policies. We had two ABOs drawn from the hospital at two different times approximately 24 hours apart that resulted in an O.
BY MS. DINKINS:

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Q Does WASH's written protocol today include a process for addressing conflicting or indeterminate blood type results?
A Yes. We have instituted a hard stop where if the patient has received multiple transfusions, that we instituted the hard stop. The medical director is the one that releases the ABO for confirmation. We have also instituted a preallocation huddle call before we begin allocation that contains the medical director, the AOC, the on-site clinician, as well as the CAT who is going to be allocating to discuss the case.
We also now have a decision tree in regards to those types of results as well as we have a playbook that we've put in place that does a step-by-step process.
Q And what is your understanding for why this procedure for dealing with indeterminate blood type results is in place?
MS. CRAIG: Object to form.
THE WITNESS: Because of this discrepancy.
BY MS. DINKINS:
Q When you say "this discrepancy," what do you mean?

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MS. CRAIG: Same objection.
THE WITNESS: This particular case, this ABO discrepancy.
BY MS. DINKINS:
Q And so is it your understanding that these procedures were put in place so that a situation like what happened with this donor would not happen again?
A Do you mean to prevent a situation? Yes.
Q In 2018, did WASH have a written protocol for addressing conflicting or indeterminate blood type results?
A No, just that we had to have two different blood types from two different draw times that resulted in the same blood type.
Q And there was no written policy about what to do if one of the blood type results came back indeterminate. Is that correct?
A If one blood type -- if the blood type came back discrepant, we were to look to draw another sample to have two samples to compare, but we found a second sample, again, which was almost 24 hours apart, same blood type, collected at the same hospital, that resulted the same.

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Q But did WASH's written protocol in 2018 include a process for addressing conflicting or indeterminate blood type results?
MS. CRAIG: Objection.
THE WITNESS: No.
BY MS. DINKINS:
Q I'm sorry. What did you say?
A No, outside of having two separate blood types that were drawn at two different times with the same result.
Q Is WASH's medical director required to review donors' medical records?
A Yes.
Q And is there a particular medical director that does that? You said WASH had four medical directors.
A It's whoever's covering for the day.
Q And does one of WASH's medical directors review the records for all donors?
A No. They currently -- in 2018, I'm not certain the practice, but currently, they review their own record in regards to the day that they're on. Now, if you're asking if there's one medical director that reviews all organ cases at the time that they're active, no, that's the --

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A Correct.
Q For the donor at issue in this case?
A Correct.
Q Why did WASH order this testing for the donor?
A These same tests are ordered on all organ donors and tissue donors.
Q When WASH ordered these tests from VRL, did it expect to use the results to help determine the donor's blood type?
A Yes.
Q Please look at Exhibit 2, which is the one Bates labeled WASH 218.
A I'm sorry. Repeat that one more time.
Q It's WASH 218.
A Okay.
Q When was the sample for this testing collected?
A Sample 218 was collected at 1900.
Q On November 25th, 2018?
A Correct.
Q Was that sample collected after the donor received blood transfusions?
MS. CRAIG: Object to form.
THE WITNESS: I don't have the blood

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administration form in front of me, so I don't know.
BY MS. DINKINS:
Q According to this VRL test report, was it collected after the donor received blood transfusions?
A Based on this -- based on this report?
Q Yes.
A I don't see where it says posttransfusion, but it should say posttransfusion somewhere. Transfusion status, post.
Q Who determined that this blood was collected posttransfusion?
A That would be the CDC who was collecting the samples at the time they're being sent.
Q And for this case, that was Michael Lotts?
A No. That would have been the day before Michael.
Q Do you know who that was?
A I do not.
Q So WASH told VRL that the sample it was sending had been collected after the donor received blood transfusions. Is that right?

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A Yes.
Q How did the CDC who collected the sample determine that the donor had received blood transfusions?
A I don't -- I don't know. I don't know how they did. I wasn't -- I don't know. I wasn't part of the case at that time, so I don't -- I don't know. You'd have to ask them.
Q Do you know how that would typically be determined?
A Ask the question for me again.
Q Do you know how a CDC collecting a donor's blood sample would typically determine whether the sample had been collected posttransfusion?
A It would access the blood administration. They would call the blood bank and access the records in combination with speaking with the blood bank to make sure we had a record of all the blood products that had been given, in particular --
Q And would that be the -- I'm sorry.
A In particular red cells.
Q Would that be the blood bank at the donor hospital?

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A Yes.
Q So do you believe in this case that the CDC would have spoken with the blood bank and reviewed the donor's records to determine whether the sample was collected posttransfusion?
MS. CRAIG: Objection. Speculation.
THE WITNESS: I don't know. I was -- I would -- you would have to ask that particular person. I don't know.
BY MS. DINKINS:
Q But is that what you would typically expect to happen?
MS. CRAIG: Objection.
THE WITNESS: Normal practice.
BY MS. DINKINS:
Q Do you have any reason to believe that the normal practice wasn't followed here?
MS. CRAIG: Same objection.
THE WITNESS: No, I don't.
BY MS. DINKINS:
Q What blood type does this report indicate for the donor?
A It's indeterminate, meaning they cannot determine the blood type.
Q And what do the comments underneath

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A To -- there are certain pieces of information for the chart to follow up for like -- that we -- that we obtain as follow-up information, like cultures, information for the coroner, things of those nature, that we -- it's part of our normal process to finish the chart up in that after the case is complete.
Q Why doesn't WASH obtain all of the chart before the donor's case is complete?
A We do. We just don't often always collect them and print them off and bring them back with us. We obtain them, in regards to the on-site person, the clinical person, speaking with the blood bank and looking at the medical record in the computer, but it's all electronic, so we wouldn't ask them to print that off to make it part of our chart to bring back because it's electronic.
Q So when was the first time you saw the lab results in Exhibit 10?
A I've never seen these.
Q Do you know whether anyone else who worked on the donor's case reviewed these?
MS. CRAIG: Objection.
THE WITNESS: I can't answer that

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question. I don't know.
BY MS. DINKINS:
Q And I believe you testified that these lab results show the donor's history of blood transfusions. Is that right?
A Yes. Remind me of that page again one more time, because when I saw it, I knew what it was, but I just wanted to make sure 100 percent certain that everything in that was all blood products.
Q It starts on 301.
A It's a transfusion record.
Q If you'll please look back at Exhibit 5 and the page labeled WASH 180.
A 0180?
Q That's right.
A I'm there.
Q And look at the entry dated 11/26 at 2312. This says that more blood needs to be drawn from the donor before the donor's organ procurement surgery, correct?
A Uh-huh, yes.
Q Why did more blood need to be drawn before the procurement surgery?
A Because this is, again, tissue,

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tissue's request for blood to be drawn outside the hemodilution window for serologies and NATs. So this was tissue requirements, not organ requirements at that point.
Q And is this saying that any blood drawn after midnight on November 27th would not be hemodiluted?
A Yes, based on that note. And again, that's for tissue.
Q I understand. If you'll look back at the call notes, which are Exhibit 8, and please look at the page labeled WASH 39.
A 039?
Q That's right.
A Okay.
Q And the entry dated 11/27 at 4:31.
A Okay.
Q This says that Michael Lotts drew blood from the donor on 11/27/18 at 0400, correct?
A Yes.
Q And this also says that Michael Lotts confirmed that the sample qualified and was not hemodiluted. Is that right?
A Yes, that's what the note says, yes.
Q So why did Michael Lotts confirm that

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the sample wasn't hemodiluted?
MS. CRAIG: Objection.
THE WITNESS: I don't know. That's a -- you would have to ask Michael that question. I don't know.
BY MS. DINKINS:
Q Do you know what was done with the blood Michael Lotts drew on November 27th at 0400?
A No, I do not. Again, that would have been a tissue request for blood.
Q Do you know whether the blood he drew at that time was sent to transplant hospitals?
A No. That blood would not have been sent to transplant hospitals. That blood would have been drawn, based on the notes previously, would be for tissue only, and the blood that we draw for the transplant centers is drawn at the OR.
Q Let's look at -- I'm going to mark Exhibit 11.
A And if you note at the top of that page at 0039 at 09:40, it states incoming call from Michael. He did do a blood draw at 0400, and sample qualifies. Patient does not have any more blood products. That, again, is in reference to